DHS/Mental Retardation/Developmental Disabilities Administration

Transmittal Letter No.

Location: **Distribution:**

SUBJECT: USE OF PSYCHOTROPIC MEDICATIONS **Date:** November 1, 2001

The attached policy is to establish guidelines, protocols, and procedures for the use of psychotropic medications for consumers of the Department of Human Services, Mental Retardation and Developmental Disabilities Administration (DHS/MRDDA) This is a companion policy to DHS/MRDDA's policy on Behavior Support and Restricted Controls. The intent of this policy to establish protocols that promote the proper consideration and oversight of the use of psychotropic medications.

This policy applies to all employees of the Department of Human Services, Mental Retardation Developmental Disabilities Administration (DHS/MRDDA) and all **individuals** and agencies that provide services or supports to **persons** with mental retardation and/or developmental disabilities through funding, contract or provider agreement with the District of Columbia. All paid staff, subcontractors and consultants of such agencies, and volunteers or other persons recruited to provide services and supports on behalf of the persons with mental retardation and other developmental disabilities, are subject to the requirements of this policy.

Revisions:

Amendments:

10/31/01

Bruce C. Blaney Date
DHS/MRDDA Administrator

11/27/01

Carolyn W. Colvin Date
DHS Director

POLICY AND PROCEDURE

Transmittal Letter No. Supersedes: Manual Location:

SUBJECT: USE OF PSYCHOTROPIC MEDICATIONS

CHAPTER: NUMBER: EFFECTIVE DATE: November 1, 2001

I. PURPOSE

This purpose of this policy is to establish guidelines, protocols, and procedures for the use of psychotropic medications for consumers of the Department of Human Services, Mental Retardation and Developmental Disabilities Administration (DHS/MRDDA). **This is a companion policy to DHS/MRDDA's policy on Behavior Support and Restricted Controls.**

II. GOALS/OBJECTIVES

The intent of this policy is to establish protocols that promote the proper consideration and oversight of the use of psychotropic medications.

III. SCOPE

This policy applies to all employees of the Department of Human Services, Mental Retardation Developmental Disabilities Administration (DHS/MRDDA) and all individuals and agencies that provide services or supports to persons with mental retardation and/or developmental disabilities through funding, contract or provider agreement with the District of Columbia. All paid staff, subcontractors and consultants of such agencies, and volunteers or other persons recruited to provide services and supports on behalf of the persons with mental retardation and other developmental disabilities, are subject to the requirements of this policy.

IV. AUTHORITY

The authority of this policy is established in D.C. Code §7-1301 et. seq.; *Evans v. the District of Columbia*, June 14, 1978; *and Evans v. Williams*, 35 F. Supp. 2d 88, 97 [D.D.C, February 10, 1999. DC Code 2-137: 2001 Plan For Compliance and Conclusion of *Evans v. Williams*; DC Code, Title 6, PL. 93-112, Human Rights Act of 1964.]

V. DEFINITIONS

Axis I Diagnosis of a Mental Disorder: Psychiatric clinical disorder or other conditions that may be a focus of clinical attention as specified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). Examples of Axis I disorders include, but are not limited to, schizophrenia, major depression, and other major affective disorders.

Behavior Support Plan: A component of the Individual Support Plan (ISP) that defines individually tailored behavior supports to assist with development of positive behaviors as a replacement for challenging behaviors. The Behavior Support Plan also provides steps and methods to help the individual address his or her challenging behaviors before employing restrictive controls.

Circle of Support: Consists of the person and members of the person's support network such as, but not limited to, family members, friends, neighbors, and professionals whom the person wishes to be a participant in his or her support network.

Chemical Restraint: Application of emergency psychotropic medication to control acute, episodic behavior that restricts movement or function of the individual for the protection of the individual or others from harm. **Prescription of psychotropic medications to persons who have not been formally assessed and determined to have an Axis I mental disorder is considered chemical restraint. PRN use of psychotropic medications is considered chemical restraint.**

Psychotropic Drug: Drug prescribed specifically to stabilize or improve mood, mental status, or behavior. Common psychotropic medications include antipsychotic, antianxiety, antidepressant, antimania, stimulant, and sedative-hypnotic classifications. Psychotropic drugs may also have non-psychiatric indications and may be used for other purposes.

Side Effects: Secondary effects of a drug that are usually undesirable and different from the therapeutic effect.

VI. POLICY

1. Access to Psychotropic Medications

It is the policy of the Department of Human Services, Mental Retardation and Developmental Disabilities Administration (DHS/MRDDA) that psychotropic medication shall only be prescribed to persons with mental retardation and/or other developmental disabilities who have a formal psychiatric assessment and an Axis I diagnosis of a mental disorder. Further, the prescription and use of psychotropic medication must be incorporated into a person's Behavior Support Plan and approved by MRDDA through its Human Rights Committee process. (Refer to DHS/MRDDA's policy on Behavior Support and Restricted Controls.)

Historically, the use of psychotropic medication for behavior management/control has been common and routine. However, recent research clearly indicates that this practice is questionable for many individuals. The long-term use of psychotropic medication can result in very debilitating side effects and often does little to lead to the development of more adaptive behavior. Yet, it must be recognized that psychotropic medication can be an integral part of treatment for some individuals, particularly those who manifest severe psychiatric disorders. When such a disorder is formally assessed and diagnosed by a physician, the use of psychotropic medications may be considered an appropriate part of routine treatment. Without a formal assessment and diagnosis of an Axis I diagnosis, use of psychotropic medications will be considered as "chemical restraints", which are prohibited by MRDDA policy.

For individuals who have been receiving psychotropic medications for a prolonged period of time, it is often necessary to make a systematic and carefully monitored attempt to reduce and/or discontinue medications in order to know if they are necessary and appropriate. For those individuals who do benefit from medication, this process also yields information that helps to establish and maintain the minimum dosages necessary for effective treatment. MRDDA encourages this process of medication reduction and discontinuation, and many individuals have been successfully and permanently weaned from psychotropic medications. For these reasons, the actual prescriptions for psychotropic medication may not exceed thirty (30) days. Prescriptions may be authorized every thirty (30) days, if needed, as determined by the prescribing psychiatrist, however, the person must have a monthly interview with a psychiatrist who reviews the response to medication, as specified in this policy.

Further, some individuals with significant developmental delay may be unable to fully understand or describe the potential risks, benefits and potential side effects of psychotropic medications. A formal behavior support plan must be developed to monitor behavioral progress and review the person's response to medication. In addition, regular updated behavioral data must be supplied to the physician in

order to ensure minimal effective dosages of psychotropic medications. For the above reasons, psychotropic medication is considered a restricted control.

The involvement of psychiatrists is mandatory. Knowledge of first-line medication responses and the most up-to date medications for psychiatric treatment is generally obtained through board-certified or board-eligible psychiatrists.

2. Appropriate Use of Psychotropic Medications

It is the policy of DHS/MRDDA that there shall be protection against the inappropriate use of psychotropic medications and from potentially serious side effects of these medications. Psychotropic medications shall not be the first treatment of choice for behavior problems. Positive behavior support approaches are equally or more effective and treatment decisions should always be made on an individual basis. Psychotropic medications to control a person's behavior or the use of psychotropic medications to substitute for other types of effective services and supports is inappropriate and limits the person's capacity to actively participate in community integrated settings. As stated, psychotropic medications shall not be used for this purpose. **The following are expressly prohibited:**

a. The PRN use of psychotropic medications.
b. All forms of chemical restraint as defined in this policy.
c. Use of psychotropic medication as punishment; to control a person's behavior; for the convenience of staff; or as a substitute for other types of services and supports.

Psychotropic medications have mild to severe side effects. Regular monitoring for side effects and evaluation of medication effectiveness is mandatory for individuals who have a reduced capacity to communicate symptoms of potential side effects. Knowledge of the common side effects of psychotropic medications and how such side effects may affect a person's health and behavior is essential. Staff shall be regularly trained to observe for side effects.

3. Development of a Behavior Support Plan

A Behavior Support Plan shall be developed for all consumers who have challenging behaviors and for whom psychotropic medication is under consideration. Whenever possible, positive behavior strategies to support the person's behavioral functioning shall be implemented prior to the prescription of psychotropic medication.

4. Guidelines for Use of Psychotropic Medications

Every provider agency under the scope of this policy shall implement a Medication Management Protocol. The Protocol shall include procedures for assessment, prescription, administration, and monitoring of psychotropic medications. The Protocol will also include a training plan for direct care and supervisory staff, and outline a curriculum on the use of psychotropic medication. Section VII of this policy describes the DHS/MRDDA process for review of provider Medication Management Protocols and training requirements.

VII. REQUIREMENTS

1. Assessment of the Need for Psychiatric Treatment

a. If a person appears to be displaying symptoms of mental illness, the person must be referred to a psychiatrist for a psychiatric assessment according to the following time standards:
   1) Within 1 hour in a psychiatric emergency - that is, the person is a danger to self or others, or has symptoms of psychosis.
   2) Within 24 hours if the person requires urgent care - that is, the person's mental status appears to be rapidly deteriorating.
   3) Within 7 days, if the person requires routine psychiatric care - that is, the person has signs and symptoms of mental illness, but is not a threat to self or others and the person's mental status does not appear to be rapidly deteriorating.

   In all of the above instances, the DHS/MRDDA case manager must be notified of the psychiatric referral.

b. Prior to the assessment, staff shall prepare a psychiatric referral summary and send or take this to the professional conducting the assessment. The summary shall briefly describe the frequency and severity of the person's symptoms or behaviors and what has been tried previously. Further, it shall include a history of psychotropic medications the person has previously taken, if known, or currently takes. See Attachment A for sample form, *Psychiatric Referral Summary.*

2. Prescription of Psychotropic Medication

a. Psychotropic medications may only be prescribed following a formal psychiatric assessment and diagnosis of an Axis I mental disorder. Prescriptions shall be effective for a thirty- (30) day period and re-prescribed only when the prescribing psychiatrist has assessed the person and determined

continued use of psychotropic medications is necessary. Otherwise, use of psychotropic medications will be considered as a "chemical restraint," which is prohibited by MRDDA policy.

b. After the formal assessment, if the psychiatrist determines the presence of an Axis I diagnosis and recommends psychotropic medication, the prescribing physician or the provider agency staff shall document the professional's treatment plan in the person's record. See Attachment B for sample form, *Psychotropic Medication Treatment Plan: Introduction of New Medication.* The plan shall address the following:
   1) The Axis I mental health diagnosis.
   2) The name(s) and purpose(s) of the medication(s).
   3) The length of time considered sufficient to determine if the medication is effective.
   4) The frequency of review by the prescribing professional, but no less than monthly to monitor the medication dosage with the goal of prescribing the lowest possible dose of the correct medication(s); and that there is ongoing monitoring and reassessment of the person's medication needs.
   5) The behavioral or other criteria to determine whether the medication is effective (i.e., what changes in behavior, mood, thought, or functioning are considered evidence that the medication is effective).
   6) Common side effects of the medication.
   7) Plan to monitor side effects.

   A Psychotropic Medication Treatment Plan must be completed when a new psychotropic medication is prescribed or there is a change in dosage of an existing medication.

c. The agency that provides residential support services shall provide written documentation of the initiation or change in psychotropic medication to the day support services provider and a copy of the Psychotropic Medication Treatment Plan. If the person resides at the family home, in foster care, or lives independently, the MRDDA case manager shall have the responsibility to notify the day support services provider of the initiation or change in psychotropic medication and provide a copy of the Psychotropic Medication Treatment Plan.

d. Informed consent by the person and/or guardian for administration of the medication shall be obtained and documented on a form that lists justification for the use of the medication. If a person is unable to provide consent and there is no available family member or guardian, then the person's team needs to seek and obtain another form of surrogate decision-making. The purpose of informed consent is to ensure the person or guardian understands the potential side effects of the medication. The major potential side effects shall be listed on the consent form in non-technical terms that a layperson can understand. See Attachment C for the sample form, Consent for Use of Psychotropic Medication.

e. Whenever a person is prescribed psychotropic medication, a Behavior Support Plan must be developed and include strategies to support the person in positive ways that will assist in the treatment or reduction of the person's symptoms/behaviors. Ideally, a Behavior Support Plan will be in place prior to the prescription of medication. Administration of prescribed medications may occur prior to the completion of the Behavior Support Plan, as long as the Behavior Support Plan is completed and reviewed by the Human Rights Committee within thirty (30) days from when the person began taking the psychotropic medication.

3. Administration

The following guidelines apply to the administration of psychotropic medication:

a. The Department of Human Services/Mental Retardation and Development Disabilities Administration (DHS/MRDDA) policy and procedures on the safe administration and handling of medications applies to the use of psychotropic medications.
b. Only appropriately trained and qualified staff are permitted to administer psychotropic medication to consumers.
c. Administration of excessive or unnecessary psychotropic medications to consumers is prohibited.
d. Administration of psychotropic medications to consumers on a PRN basis is prohibited.
e. Administration of psychotropic medications as a punishment, for the convenience of staff, as a substitute for programming, or in quantities that interfere with a person's individual developmental goals and activities is prohibited.
f. Administration of sedatives/antianxiety agents or other psychotropic medication prior to medical or dental appointments on a PRN basis is prohibited. Implementation of behavior support strategies to assist the person with increasing more appropriate, replacement, and coping skills to enable attendance at medical appointments shall be the first response, followed by the development of a Behavior Support Plan, if additional behavior supports are necessary. The Behavior Support Plan may specify the need to assess use of sedatives/antianxiety agents or other psychotropic medication; however, a physician's order is necessary each time medication is administered.

4. Emergency Provisions

Psychotropic medication may be prescribed to prevent the immediate deterioration of a person's mental status when a person manifests severe psychiatric symptoms, and when prescribed by a licensed physician. Prescription of psychotropic medication under these circumstances is considered a Serious Reportable Incident and an incident report must be filed with MRDDA.

In the event that a non-psychiatrist prescribes psychotropic medication to prevent the immediate deterioration of the person' mental status, a board eligible or board-certified psychiatrist must conduct an assessment of the individual within thirty (30) days. Psychotropic medication may be continued only when the person has an Axis I diagnosis of a mental disorder, and the psychiatrist's assessment concurs with the need for psychotropic medication.

5. Monitoring Psychotropic Medications

a. General Monitoring Requirements:

1) All staff that works with consumers who are prescribed psychotropic medication must immediately report any side effects and/or adverse reactions of the medication to their supervisor and the prescribing physician.
2) The prescribing psychiatrist shall establish a review protocol as part of the treatment plan and see the person at least once per month, unless there is no progress, in which case, meetings shall be held sooner.
3) To assist the psychiatrist with information about the person's response to medication, including any suspected side effects, the behavior consultant and the residential and day support providers shall have a proactive role in documenting and providing information to the prescribing psychiatrist, using DHS/MRDDA Psychotropic Medication Monitoring Forms, Attachment D 1-2.
4) If the person does not receive residential supports, the MRDDA case manager shall have the primary responsibility to monitor the person's response to medication and any suspected side effects. The case manager shall confer with the person and his/her circle of support, including the day support provider, if any, and shall complete and submit the DHS/MRDDA Psychotropic Medication Monitoring Form (Attachment D-1) to the prescribing psychiatrist.

b. Weekly Review: Weekly review of the person's response to psychotropic medication shall occur during the first thirty (30) days of administration of a new medication. The purpose of the weekly review is to monitor side effects of the medication. Residential and day support staff or the case manager (if the person does not receive residential or day supports) shall monitor the common side effects of the medication (as listed on the treatment plan), and any apparent change in the person's physical or psychological health. Staff shall document and

provide information to the prescribing psychiatrist weekly, or sooner if the person experiences an adverse reaction or side effects, using the DHS/MRDDA Psychotropic Medication Monitoring Form D-1.

c. **Monthly Review:** A monthly review of the person's response to psychotropic medication shall be held and include the following:

1) The behavior consultant shall summarize the effectiveness of the Behavior Support Plan as well as any changes that have been made to such a plan.
2) The residential and day support provider shall designate staff to help monitor the person's response to medication, including side effects. Such staff shall complete and submit the Medication Monitoring Form to the prescribing psychiatrist.

d. **Periodic Reviews**: The agency shall designate staff to periodically monitor the person for side effects using a standardized assessment instrument and inform the prescribing professional of the results, according to the following schedule:

1) Monitoring for side effects shall occur within 1 month of administration of a new psychotropic medication and every 3-6 months thereafter, depending on the prescribing professional's recommendations.

2) Use of a standardized instrument to monitor side effects will assist the agency with tracking changes in behavior and/or health, which might be side effects of the medication. A sample standardized side effect assessment scale "Monitoring of Side Effect Scale (MOSES)" is included as Attachment E[1].

3) Further, a nurse or psychiatrist must monitor the potential development of tardive dyskinesia using the Abnormal Involuntary Movement Scale, Attachment F, at least every 6 months, for persons who are prescribed anti-psychotic medication. A baseline assessment using this scale must be completed within 3 working days from when the person begins taking the anti-psychotic medication.

e. **Annual Continuation of Medication Reviews**: In addition to the monthly and periodic reviews described, the residential support provider, or the case manager if there is no residential support provider, shall arrange an appointment for the person with the prescribing professional annually. The purpose of the annual review is to assess the continued need for psychotropic medication and whether the lowest possible dose of the correct medication is prescribed. The annual review must be documented in a standard format that addresses the rationale for continuation of psychotropic medication, if continued, and the dosage. See Attachment G for sample form, *Psychotropic Medication Treatment Plan: Annual Continuation of Medication.* In preparation for the annual review, the residential

support provider or the case manager shall arrange for and submit the following information to the prescribing psychiatrist prior to the annual review appointment:

1) Description of the symptoms of mental illness for which the medication was prescribed and any changes in symptoms.
2) A summary of any changes in the ISP and/or the Behavior Support Plan.
3) A summary of the monthly and periodic reviews.
4) A list of prescribed and over-the- counter medication the person takes.
5) Any identified health issues since the last annual review.
6) Positive results of the medication, if observed.
7) Any noticeable side effects.

f. A Human Rights Committee must review the results of the Annual Continuation of Medication Review.

6. Responsibility

a. If a person resides in a provider-operated residence, the provider agency shall be responsible for arranging the assessment, prescription, administration, and monitoring the use of psychotropic medications consistent with the requirements of this policy. The DHS/ MRDDA case manager shall be a resource to the person and the provider agency and assist with the development of a Behavior Support Plan in accordance with the policy on Behavior Support and Restricted Controls, and shall monitor the results of and whether the monthly, periodic, and annual reviews occur.

b. If a person resides at a family home, a foster care home, or lives independently, the DHS/MRDDA case manager will assist the person with obtaining a psychiatric assessment and prescription, and develop a plan with the person to monitor the effectiveness of the medication and any potential side effects. The DHS/MRDDA Case Manager shall assist with the development of a Behavior Support Plan in accordance with the policy on Behavior Support and Restricted Controls. Further, the case manager shall facilitate implementation of the Behavior Support Plan and the Psychotropic Medication Treatment Plan in these settings, including arranging for consultation or training to assist family members and others the person wishes to include in their circle of support. The case manager shall also have responsibility for informing the day support services provider, if any, and shall facilitate completion of the weekly, monthly, periodic, and annual reviews.

7. Training

a. Only staff that participates in competency-based training on psychotropic medication is qualified to administer and monitor the use of such medications. Training on psychotropic medications shall occur during the orientation of each new employee, and at least annually thereafter. There shall be three levels of training:

1) Comprehensive training for nursing staff; house managers, QMRPs, and case managers.
2) Specific job-related training for direct care staff that focuses on identifying the potential need for psychotropic medication, the effectiveness of the medication, and the development of side effects.
3) Targeted in-service educational sessions for behavior consultants and psychiatrists on the serving the unique needs of people with mental retardation and other developmental disabilities.

b. The Comprehensive Training Curriculum for house managers, case manager and nursing personnel shall include, but not be limited to, the following key areas:
   1) Symptoms of mental illness.
   2) Myths about behavior and mental illness in people with MR/DD.
   3) Behavioral equivalents of depression and mania.
   4) Behavioral equivalents of other mental illnesses.
   5) Psychotropic drug classes and specific drugs.
   6) Side effects of psychotropic medications and adverse behavioral effects.
   7) Adverse behavioral effects of antiepileptic medications.
   8) Use of standardized side effect assessment scale to monitor side effects.
   9) Recognizing when to contact medical personnel.
   10) Health Care Financing Administration General Safety Precautions for Psychopharmacological Medications for People with Developmental Disabilities[2].
   11) International Consensus Conference on Psychopharmacology Guidelines for the Use of Psychotropic Medication with Individual with Developmental Disabilities.
   12) Documentation requirements.

c. Specific job-related training for direct care staff shall include, but not be limited to, the following:
   1) Recognizing the need for psychotropic medication.
   2) Recognizing the side effects of psychotropic medications and adverse behavioral effects.
   3) Recognizing adverse behavioral effects of antiepileptic medications.
   4) Recognizing when to contact medical personnel.
   5) Assessing whether the medication is achieving desired results.
   6) Documentation requirements.
   7) Specific medication regimen and side effects for persons the staff supports.

d. In-Service Education for Behavior Consultants and Psychiatrists shall include:
   1) Needs of people with mental retardation and other developmental disabilities.
   2) Myths about behavior and mental illness in people with MR/DD.
   3) Behavioral equivalents of depression and mania.
   4) Behavioral equivalents of other mental illnesses.
   5) Assessing whether the medication is achieving desired results.
   6) MRDDA policy and documentation requirements.

VIII. PROVIDER PROTOCOLS

Each provider agency under the scope of this policy shall submit a Psychotropic Medication Management Protocol to the Clinical Services Division of DHS/MRDDA within sixty (60) days of the effective date of this policy. New provider agencies must submit a Psychotropic Medication Management Protocol to the Clinical Services Division within thirty (30) days of referral of the first consumer.

IX. EXCEPTIONS

Any exception of this policy must be reviewed and approved in writing by the Administrator of MRDDA.

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[1] Kalachnik, J.E. (1985) Monitoring for side effects system (MOSES). Unpublished manuscript. In N.A. Weiseler, R.H. Hanson, G. Sipierstein, (Eds). *Challenging Behavior of Persons with Mental Health Disorders and Severe Developmental Disabilities* (1999). American Association on Mental Retardation, Washington, D.C.

[2] Health Care Financing Administration (1996). *Psychopharmacological Medications. Safety Precautions for Persons with Developmental Disabilities. A Resource for Training and Education.* Washington, DC: US Department of Health and Human Services.

Psychotropic Medication Referral Summary
Attachment A-1

Consumer's Name _____

Birthdate _____ Age Sex: ☐Male ☐Female

Address _____

Supporting Agency: _____

Contact Person: _____ Phone _____

Legal Guardian? _____ Phone _____

Primary M.D. _____ Phone _____

Other M.D. _____ Phone _____

Disability(ies): _____

MRDDA Case/Resource Manager _____ Phone: _____

Form completed by: _____ Date: _____ Relationship _____

Past History:

Previous Mental Health Involvement (list past counseling, behavioral interventions, diagnosis, psychiatric hospitalizations, risis team contact, etc.):

_____

_____

_____

_____

Previous Psychotropic Medication _____

_____

What has been tried previously (list intervention, if known) _____

_____

List any known unusual or adverse reactions to medication _____

_____

Current Issues:

Briefly describe why this person is being referred for a psychiatric evaluation:

_____

_____

_____

_____

Psychotropic Medication Referral Summary
Attachment A-2

Consumer's Name_____ Date_____

Current Symptom(s)/Behavior(s) of concern (define, state frequency and severity of each symptom or behavior):

_____

_____

_____

_____

List Other Agency Contacts and Phone Numbers (vocational, mental health, other therapists, etc.):

_____

_____

_____

_____

List Current Medical Concerns/Diagnoses	Current Medications/Daily Dose/Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Describe the following characteristics of the person, if not already listed:

Sleep Pattern _____

Mood/Affect _____

Eating/Appetite _____

Thinking/Cognition _____

Memory_____

Anxiety Level _____

Hyperactivity _____

Sensory Impairments _____

Allergies _____

Gynecological/Urinary Problems _____

Communication Impairment _____

Other Information that may be pertinent_____

_____

_____

Psychotropic Medication Treatment Plan - Attachment B

(Check one)

❒Introduction of New Medication

❒Change in Dosage

Consumer's Name: _____ Date: _____

Birthdate: _____ Address: _____

Supporting Agency: _____

Axis I Diagnosis: _____

Symptoms of Mental Illness: _____

❒ Yes ❒ No Physician received Psychotropic Medication Referral Summary for new referrals

❒ Yes ❒ No Physician received information from residential, day support, or case management (Form D-1) for change in dosage assessments.

Physician Conclusion:

Medication: _____ **Dosage:** _____

- ❒ No action necessary
- ❒ Dose reduction
- ❒ Drug discontinuation
- ❒ Drug hold
- ❒ Drug change
- ❒ Increased surveillance
- ❒ Lab or other tests (specify)

Length of Treatment Trial (considered sufficient to determine if medication is effective):

_____

_____

_____

Criteria to Evaluate Effectiveness of Medication (what changes in, mood, thought or functioning should be expected):

_____

_____

_____

Common Side Effects of the Medication(s)

_____

_____

Monitoring Plan (including monthly follow-up appointment): _____

_____

_____

Physician: _____ Provider Staff: _____

Telephone: _____ Telephone: _____

Consent for Use of Psychotropic Medication -Attachment C

(Use when introducing a new medication **OR** a change in dosage)

Consumer Name: _____ Date: _____

Birthdate _____ Sex: ☐ Male ☐ Female

Medication for Which Consent is Requested: _____

_____

Purpose for Which Medication is Prescribed:

_____

_____

Information on Medication:

Dosage and Range:

_____

Possible Common Side Effects _____

_____

_____

_____

_____

Questions regarding the use of this medication should be addressed to the prescribing physician listed below.

Name of Physician _____ Telephone #: _____

Consent Statement:

I have received information on this medication, the reasons for its use, and I have had the opportunity to get my questions about it answered. I consent to the use of this medication. I understand that failure to consent to this medication will not result in loss of services from the Mental Retardation Developmental Disabilities Administration (MRDDA). I also understand that I may withdraw my consent at any time, without loss of services from the Mental Retardation Developmental Disabilities Administration.

_____ _____

Signature of Consumer Date

_____ _____

Signature of Guardian Date

MRDDA/DHS Psychotropic Medication Monitoring Form
Residential and Day Support Staff and Case Manager
Attachment D-1

Consumer's Name_____ Birthdate _____

Address_____

Supporting Agency: _____

Axis I Diagnosis for Which Medication is Prescribed: _____

_____

Symptoms of Mental Illness for Which Medication is Prescribed: _____

_____

Medication: _____ _____ Dosage: _____

Common Side Effects of the Specific Medication as noted on the Psychotropic Medication Treatment Plan:

_____

_____

Monitoring Review Period:
(dates)_____

Response to Medication: (*to be completed by Residential and Day Support Staff, Case Manager*) Have you observed or has the consumer commented on changes in his/her mood, thoughts, behavior or functioning?

☐ Yes ☐ No Please describe, using specific examples: _____

_____

_____

_____

Have you observed or has the consumer complained of any common side effects (listed above) associated with this medicine? Or any other potential side effects? ☐ Yes ☐ No

Please describe: _____

_____

_____

_____

_____

Signature and Printed Name of Person Who Completed This Form Date

MRDDA/DHS Psychotropic Medication Monitoring Form
Behavior Consultant
Attachment D-2

Consumer's Name: _____ Birthdate _____

Address: _____

Supporting Agency: _____

Monitoring Review Period: (dates) _____

Summary of Effectiveness of Behavior Support Plan _____

Changes in the Consumer's Behavior Support Plan _____

Printed Name & Signature of Behavior Consultant: _____ Date

Annual Continuation of Psychotropic Medication
Attachment E

Consumer's Name _____ Date _____

Address _____

Supporting Agency _____

Symptoms of Mental Illness:

_____

_____

☐ Yes ☐No Physician received information from Behavior Consultant (Form D-2)

☐ Yes ☐No Physician received information from residential/ day support or case management (Form D-1)

☐ Yes ☐No Physician received results of formal assessment of side effects completed by nurse or physician.

Physician Conclusion:

Medication:

Dosage:

☐ No action necessary
☐ Dose reduction
☐ Drug discontinuation
☐ Drug hold
☐ Drug change
☐ Increased surveillance
☐ Lab or other tests (specify)

Diagnosis and Symptoms of Mental Illness for Which Medication is Prescribed:

_____

_____

Positive Results of this Medication and Justification for Continuation _____

_____

_____

Plan to Continue Use of This Medication _____

_____

_____ _____

Prescribing Physician Provider Agency Staff

Attachment F
Monitoring of Side Effects Scale (MOSES)

The attached scale, MOSES, is a sample of a formal side effect monitoring scale.

Monitoring of Side Effect Scale (MOSES)

Rating Date	Client Name
Rater Signature & Title	

Scoring: See page 2 for details

0: None 1: Minimal 2: Mild 3: Moderate 4: Severe NA: Not Assessable

Instructions: See page 2. Bold items below are primarily observable. Regular print items are primarily client verbalization, staff input, or chart review.

Exam Type (Check one; if "other," specify in rater comments)

☐ Admission ☐ Baseline ☐ Dose Increase ☐ Drug Initiation ☐ 6-month ☐ Other

Ears/Eyes/Head		Musculoskeletal/Neurological		Urinary/Genital	
01. Blink Rate: Decreased	0 1 2 3 4 NA	**29. Arm Swing: Decreased**	0 1 2 3 4 NA	59. menstruation: absent/ irregular	**While the side-effects in these two areas are often difficult to determine, please be aware they may occur depending on the specific drug profile. Be certain to inquire about these if the client is verbal.**
02. Eyes: Rapid Vert/Horz	0 1 2 3 4 NA	**30. Contortions/Neck-Back Arching**	0 1 2 3 4 NA	60. sexual: activity decreased	
03. Eyes: Rolled Up	0 1 2 3 4 NA	**31. Gait: Imbalance/ Unsteady**	0 1 2 3 4 NA	61. sexual: activity increased	
04. Face: No Expression/ Masked	0 1 2 3 4 NA	**32. Gait: Shuffling**	0 1 2 3 4 NA	62. sexual: continual erection	
05. Tics/Grimace	0 1 2 3 4 NA	**33. Limb Jerking/Writhing**	0 1 2 3 4 NA	63. sexual: erection inability	
06. blurred/double vision	0 1 2 3 4 NA	**34. Movement: Slowed/ Lack Of**	0 1 2 3 4 NA	64. sexual: orgasm difficult	
07. ear ringing	0 1 2 3 4 NA	**35. Pill Rolling**	0 1 2 3 4 NA	65. urinary retention	
08. headache	0 1 2 3 4 NA	**36. Restlessness/Pacing/ Can't Sit Still**	0 1 2 3 4 NA	66. urination: decreased	
Mouth		**37. Rigidity/complaints of muscle pains or aches**	0 1 2 3 4 NA	67. urination: difficult/painful	
09. Drooling/Pooling	0 1 2 3 4 NA	**38. Tremor/Shakiness**	0 1 2 3 4 NA	68. urination: increased	
10. Dry Mouth	0 1 2 3 4 NA	39. complaints of jitteriness/ jumpiness	0 1 2 3 4 NA	69. urination: nocturnal/enuresis	
11. Gum Growth	0 1 2 3 4 NA	40. fainting/dizziness/upon standing	0 1 2 3 4 NA	**Psychological**	
12. Mouth/Tongue Movement	0 1 2 3 4 NA	41. seizures: increased	0 1 2 3 4 NA	**70. Agitation**	0 1 2 3 4 NA
13. Speech: Slurred/ Difficult/Slow	0 1 2 3 4 NA	42. tingling/numbness	0 1 2 3 4 NA	**71. Confusion**	0 1 2 3 4 NA
Nose/Throat/Chest		43. weakness/fatigue	0 1 2 3 4 NA	72. Crying/feelings of sadness	0 1 2 3 4 NA
14. Breast: Discharge	0 1 2 3 4 NA	**Skin**		73. **Drowsiness**/Lethargy/ Sedation	0 1 2 3 4 NA
15. Breast: Swelling	0 1 2 3 4 NA	**44. Acne**	0 1 2 3 4 NA	**74. Irritability**	0 1 2 3 4 NA
16. Labored Breathing	0 1 2 3 4 NA	**45. Bruising: Easy/ Pronounced**	0 1 2 3 4 NA	**75. Withdrawn**	0 1 2 3 4 NA
17. Nasal Congestion/ Runny Nose	0 1 2 3 4 NA	**46. Color: Blue/Coldness**	0 1 2 3 4 NA	76. attention/concentration difficulty	**If seen:** • **Circle item** • **Enter under "Other"** • **Assign intensity score**
18. Sore Throat/Redness	0 1 2 3 4 NA	**47. Color: Flushing/Warm To Touch**	0 1 2 3 4 NA	77. morning "hangover"	
19. Swallowing: Difficult	0 1 2 3 4 NA	**48. Color: Pale/Pallor**	0 1 2 3 4 NA	78. nightmares/vivid dreams	
Gastrointestinal		**49. Color: Yellow**	0 1 2 3 4 NA	79. perceptual: hallucinations/ delusions	
20. **Vomiting**/nausea	0 1 2 3 4 NA	**50. Dry/Itchy**	0 1 2 3 4 NA	80. sleep: excessive	
21. abdominal pain	0 1 2 3 4 NA	**51. Edema**	0 1 2 3 4 NA	81. sleep: insomnia	
22. appetite: decreased	0 1 2 3 4 NA	**52. Hair: Abnormal Growth**	0 1 2 3 4 NA	**Other**	
23. appetite: increased	0 1 2 3 4 NA	**53. Hair: Loss**	0 1 2 3 4 NA		
24. constipation	0 1 2 3 4 NA	**54. Rash/Hives**	0 1 2 3 4 NA		
25. diarrhea	0 1 2 3 4 NA	**55. Sunburns/Redness**	0 1 2 3 4 NA		
26. flatulence	0 1 2 3 4 NA	**56. Sweating: Decreased**	0 1 2 3 4 NA		
27. taste abnormality: metallic, etc.	0 1 2 3 4 NA	**57. Sweating: Increased**	0 1 2 3 4 NA		
28. thirst: Increased	0 1 2 3 4 NA	58. Chills	0 1 2 3 4 NA		

Measures

Blood Pressure: _____ Pulse: _____ Temperature: _____ Weight: _____
Other (specify):

Client Name:

Current Psychotropic, Antiepileptic, Other Drugs of Importance (e.g., anticholinergics, stool softeners, etc.), and Total Mg/Day

_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day

Rater Comments (cross-reference chart location if more space needed)

Is more specialized assessment data required or likely to be needed?
(e.g., more specific rating scale, assessment using behavioral measures, etc.)
☐ Yes (describe in comments) ☐ No

Rater Conclusion:
☐ Immediate action required: Physician review at next visitor quarterly meeting
☐ Action required: Semi-immediate physician review (57 days)
☐ Action required: Immediate physician review (572 hours)

Physician Comments (cross-reference chart location if more space needed)

Physician Conclusion (check one or more):

☐ No action necessary	☐ Contra-active/auxiliary drug
☐ Dose reduction	☐ Drug change
☐ Drug discontinuation	☐ Increased surveillance
☐ Drug-hold	☐ Lab or other tests/data

Physician Signature	Date of Review

Instructions:

1. Observe the client for 5-15 minutes in a quiet area.
2. Perform procedures to ascertain items (e.g., flex arm for rigidity, open mouth to check throat and saliva, watch arm swing while walking, etc.). If client is verbal, inquire as to problems on items (e.g., "Are you having trouble seeing what you read? Describe this to me"). If client is verbal, ask at least once an open-ended question (e.g., "How have you been feeling?" or "Is there anything bothering you we need to know about?").
3. Review data such as seizure counts. If possible, talk to and review comments by reliable staff, especially on items which cannot be directly observed during the exam such as eating or sleeping.
4. If a sign or symptom is present, it is scored. This does not mean it is necessarily a side effect. If an item is scored and an explanation exists, describe this in the RATER COMMENTS (e.g., the client displays severe tremor, but is 80 years old and has had severe tremor as part of diagnosed Parkinson's disease).
5. Document in the client's chart that the assessment was conducted. Provide the form to the prescriber for review and signature.
6. The prescriber reviews the assessment, determines and documents appropriate action, and signs the form.
7. The form is filed in client's chart according to facility procedure. Any follow-up actions should be documented in the chart.
8. Refer to the exam and summarize in regularly scheduled quarterly or other medication reviews. Summarize in such reviews the results or status of any follow-up actions.

Scoring:

(Bold items are primarily observable. Regular print items are primarily client verbalization, staff input, or chart review)

0: Not Present. The item is not observable or is within the range of normal.

1: Minimal. The item is difficult to detect. It is questionable if the item is in the upper range of normal. The client does not notice or comment on the item. Alternatively, the item may occur a couple of times in a noticeable but short non-intense and non-repetitive manner.

2: Mild. The item is present, but does not hinder the client's normal functioning; i.e., his or her level at pretreatment. While the client is in no extreme discomfort, it is annoyance to the client or may progress to future severity and problems if ignored. Alternatively, the item may be continuously displayed in a non-intense manner or may "come and go" several times in a noticeable but non-intense manner.

3: Moderate. The item is present and produces some degree of impairment to functioning, but is not hazardous to health. Rather, it is uncomfortable and/or embarrassing to the client. Alternatively, the item may be displayed in a semi-intense manner "more often than not."

4: Severe. The item is a definite hazard to well-being. There is significant impairment of functioning or incapacitation. Alternatively, the item may be displayed in an intense and continuous or nearly continuous manner.

NA: The item is not assessable. The client will not cooperate with the item, appropriate data is not available, etc.

This is not a complete listing of all possible adverse drug reactions or effects and is not a substitute for other appropriate professional health care responsibilities, assessments, or testing

Client Name:

Current Psychotropic, Antiepileptic, Other Drugs of Importance (e.g., anticholinergics, stool softeners, etc.), and Total Mg/Day

_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day

Rater Comments (cross-reference chart location if more space needed)

Is more specialized assessment data required or likely to be needed?
(e g , more specific rating scale, assessment using behavioral measures, etc.)

☐ Yes (describe in comments) ☐ No

Rater Conclusion:

☐ No immediate action required. Physician review at next visit or quarterly meeting
☐ Action required: Semi-immediate physician review (57 days)
☐ Action required: Immediate physician review (572 hours)

Instructions:

1. Observe the client for 5-15 minutes in a quiet area.
2. Perform procedures to ascertain items (e.g., flex arm for rigidity, open mouth to check throat and saliva, watch arm swing while walking, etc.). If client is verbal, inquire as to problems on items (e.g., "Are you having trouble seeing what you read? Describe this to me"). If client is verbal, ask at least once an open-ended question (e.g., "How have you been feeling?" or "Is there anything bothering you we need to know about?").
3. Review data such as seizure counts. If possible, talk to and review comments by reliable staff, especially on items which cannot be directly observed during the exam such as eating or sleeping.
4. If a sign or symptom is present, it is scored. This does not mean it is necessarily a side effect. If an item is scored and an explanation exists, describe this in the RATER COMMENTS (e.g., the client displays severe tremor, but is 80 years old and has had severe tremor as part of diagnosed Parkinson's disease).
5. Document in the client's chart that the assessment was conducted. Provide the form to the prescriber for review and signature.
6. The prescriber reviews the assessment, determines and documents appropriate action, and signs the form.
7. The form is filed in client's chart according to facility procedure. Any follow-up actions should be documented in the chart.
8. Refer to the exam and summarize in regularly scheduled quarterly or other medication reviews. Summarize in such reviews the results or status of any follow-up actions.

Physician Comments (cross-reference chart location if more space needed)

Physician Conclusion (check one or more):

☐ No action necessary	☐ Contra-active/auxiliary drug
☐ Dose reduction	☐ Drug change
☐ Drug discontinuation	☐ Increased surveillance
☐ Drug-hold	☐ Lab or other tests/data

Physician Signature	**Date of Review**

Scoring:

(Bold items are primarily observable. Regular print items are primarily client verbalization, staff input, or chart review)

0: Not Present. The item is not observable or is within the range of normal.

1: Minimal. The item is difficult to detect. It is questionable if the item is in the upper range of normal. The client does not notice or comment on the item. Alternatively, the item may occur a couple of times in a noticeable but short non-intense and non-repetitive manner.

2: Mild. The item is present, but does not hinder the client's normal functioning; i.e., his or her level at pretreatment. While the client is in no extreme discomfort, it is annoyance to the client or may progress to future severity and problems if ignored. Alternatively, the item may be continuously displayed in a non-intense manner or may "come and go" several times in a noticeable but non-intense manner.

3: Moderate. The item is present and produces some degree of impairment to functioning, but is not hazardous to health. Rather, it is uncomfortable and/or embarrassing to the client. Alternatively, the item may be displayed in a semi-intense manner "more often than not."

4: Severe. The item is a definite hazard to well-being. There is significant impairment of functioning or incapacitation. Alternatively, the item may be displayed in an intense and continuous or nearly continuous manner.

NA: The item is not assessable. The client will not cooperate with the item, appropriate data is not available, etc.

This scale is not a complete listing of all possible adverse drug reactions or effects and is not a substitute for other appropriate professional health care responsibilities, assessments, or testing

Administration of the Attached Form, Abnormal Involuntary Movement Scale is mandatory at six-month intervals for persons who are prescribed anti-psychotic psychotropic medication(s).

Client Name:

Current Psychotropic, Antiepileptic, Other Drugs of Importance (e.g., anticholinergics, stool softeners, etc.), and Total Mg/Day

_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day

Rater Comments (cross-reference chart location if more space needed)

Is more specialized assessment data required or likely to be needed?
(e.g., more specific rating scale, assessment using behavioral measures, etc.)

☐ Yes (describe in comments) ☐ No

Rater Conclusion:

☐ No immediate action required: Physician review at next visit or quarterly meeting

☐ Action required: Semi-immediate physician review (57 days)

☐ Action required: Immediate physician review (572 hours)

Instructions:

1. Observe the client for 5-15 minutes in a quiet area.
2. Perform procedures to ascertain items (e.g., flex arm for rigidity, open mouth to check throat and saliva, watch arm swing while walking, etc.). If client is verbal, inquire as to problems on items (e.g., "Are you having trouble seeing what you read? Describe this to me"). If client is verbal, ask at least once an open-ended question (e.g., "How have you been feeling?" or "Is there anything bothering you we need to know about?").
3. Review data such as seizure counts. If possible, talk to and review comments by reliable staff, especially on items which cannot be directly observed during the exam such as eating or sleeping.
4. If a sign or symptom is present, it is scored. This does not mean it is necessarily a side effect. If an item is scored and an explanation exists, describe this in the RATER COMMENTS (e.g., the client displays severe tremor, but is 80 years old and has had severe tremor as part of diagnosed Parkinson's disease).
5. Document in the client's chart that the assessment was conducted. Provide the form to the prescriber for review and signature.
6. The prescriber reviews the assessment, determines and documents appropriate action, and signs the form.
7. The form is filed in client's chart according to facility procedure. Any follow-up actions should be documented in the chart.
8. Refer to the exam and summarize in regularly scheduled quarterly or other medication reviews. Summarize in such reviews the results or status of any follow-up actions.

Physician Comments (cross-reference chart location if more space needed)

Physician Conclusion (check one or more):

☐ No action necessary	☐ Contra-active/auxiliary drug
☐ Dose reduction	☐ Drug change
☐ Drug discontinuation	☐ Increased surveillance
☐ Drug-hold	☐ Lab or other tests/data

Physician Signature	Date of Review

Scoring:

(Bold items are primarily observable. Regular print items are primarily client verbalization, staff input, or chart review)

0: Not Present. The item is not observable or is within the range of normal.

1: Minimal. The item is difficult to detect. It is questionable if the item is in the upper range of normal. The client does not notice or comment on the item. Alternatively, the item may occur a couple of times in a noticeable but short non-intense and non-repetitive manner.

2: Mild. The item is present, but does not hinder the client's normal functioning; i.e., his or her level at pretreatment. While the client is in no extreme discomfort, it is annoyance to the client or may progress to future severity and problems if ignored. Alternatively, the item may be continuously displayed in a non-intense manner or may "come and go" several times in a noticeable but non-intense manner.

3: Moderate. The item is present and produces some degree of impairment to functioning, but is not hazardous to health. Rather, it is uncomfortable and/or embarrassing to the client. Alternatively, the item may be displayed in a semi-intense manner "more often than not."

4: Severe. The item is a definite hazard to well-being. There is significant impairment of functioning or incapacitation. Alternatively, the item may be displayed in an intense and continuous or nearly continuous manner.

NA: The item is not assessable. The client will not cooperate with the item, appropriate data is not available, etc.

This scale is not a complete listing of all possible adverse drug reactions or effects and is not a substitute for other appropriate professional health care responsibilities, assessments, or testing.

Administration of the Attached Form, Abnormal Involuntary Movement Scale is mandatory at six-month intervals for persons who are prescribed anti-psychotic psychotropic medication(s).

Monitoring of Side Effect Scale (MOSES)

Rating Date	Client Name

Rater Signature & Title

Scoring: See page 2 for details

0: None 2: Mild 4: Severe
1: Minimal 3: Moderate NA: Not Assessable

Instructions: See page 2. Bold items below are primarily observable. Regular print items are primarily client verbalization, staff input, or chart review.

Exam Type (Check one; if "other," specify in rater comments)

☐ Admission ☐ Baseline ☐ Dose Increase ☐ Drug Initiation ☐ 6-month ☐ Other

Ears/Eyes/Head		Musculoskeletal/Neurological		Urinary/Genital	
01. Blink Rate: Decreased	0 1 2 3 4 NA	**29. Arm Swing: Decreased**	0 1 2 3 4 NA	59. menstruation: absent/ irregular	While the side-effects in these two areas are often difficult to determine, please be aware they may occur depending on the specific drug profile. Be certain to inquire about these if the client is verbal.
02. Eyes: Rapid Vert/Horz	0 1 2 3 4 NA	**30. Contortions/Neck-Back Arching**	0 1 2 3 4 NA	60. sexual: activity decreased	
03. Eyes: Rolled Up	0 1 2 3 4 NA	**31. Gait: Imbalance/ Unsteady**	0 1 2 3 4 NA	61. sexual: activity increased	
04. Face: No Expression/ Masked	0 1 2 3 4 NA	**32. Gait: Shuffling**	0 1 2 3 4 NA	62. sexual: continual erection	
05. Tics/Grimace	0 1 2 3 4 NA	**33. Limb Jerking/Writhing**	0 1 2 3 4 NA	63. sexual: erection inability	
06. blurred/double vision	0 1 2 3 4 NA	**34. Movement: Slowed/ Lack Of**	0 1 2 3 4 NA	64. sexual: orgasm difficult	
07. ear ringing	0 1 2 3 4 NA	**35. Pill Rolling**	0 1 2 3 4 NA	65. urinary retention	
08. headache	0 1 2 3 4 NA	**36. Restlessness/Pacing/ Can't Sit Still**	0 1 2 3 4 NA	66. urination: decreased	
Mouth		**37. Rigidity**/complaints of muscle pains or aches	0 1 2 3 4 NA	67. urination: difficult/painful	
09. Drooling/Pooling	0 1 2 3 4 NA	**38. Tremor/Shakiness**	0 1 2 3 4 NA	68. urination: increased	
10. Dry Mouth	0 1 2 3 4 NA	39. complaints of jitteriness/ jumpiness	0 1 2 3 4 NA	69. urination: nocturnal/enuresis	
11. Gum Growth	0 1 2 3 4 NA	40. fainting/dizziness/upon standing	0 1 2 3 4 NA	**Psychological**	
12. Mouth/Tongue Movement	0 1 2 3 4 NA	41. seizures: increased	0 1 2 3 4 NA	**70. Agitation**	0 1 2 3 4 NA
13. Speech: Slurred/ Difficult/Slow	0 1 2 3 4 NA	42. tingling/numbness	0 1 2 3 4 NA	**71. Confusion**	0 1 2 3 4 NA
Nose/Throat/Chest		43. weakness/fatigue	0 1 2 3 4 NA	**72. Crying**/feelings of sadness	0 1 2 3 4 NA
14. Breast: Discharge	0 1 2 3 4 NA	**Skin**		**73. Drowsiness**/Lethargy/ Sedation	0 1 2 3 4 NA
15. Breast: Swelling	0 1 2 3 4 NA	**44. Acne**	0 1 2 3 4 NA	**74. Irritability**	0 1 2 3 4 NA
16. Labored Breathing	0 1 2 3 4 NA	**45. Bruising: Easy/ Pronounced**	0 1 2 3 4 NA	**75. Withdrawn**	0 1 2 3 4 NA
17. Nasal Congestion/ Runny Nose	0 1 2 3 4 NA	**46. Color: Blue/Coldness**	0 1 2 3 4 NA	76. attention/concentration difficulty	If seen: • Circle item • Enter under "Other" • Assign intensity score
18. Sore Throat/Redness	0 1 2 3 4 NA	**47. Color: Flushing/Warm To Touch**	0 1 2 3 4 NA	77. morning "hangover"	
19. Swallowing: Difficult	0 1 2 3 4 NA	**48. Color: Pale/Pallor**	0 1 2 3 4 NA	78. nightmares/vivid dreams	
Gastrointestinal		**49. Color: Yellow**	0 1 2 3 4 NA	79. perceptual: hallucinations/ delusions	
20. Vomiting/nausea	0 1 2 3 4 NA	**50. Dry/Itchy**	0 1 2 3 4 NA	80. sleep: excessive	
21. abdominal pain	0 1 2 3 4 NA	**51. Edema**	0 1 2 3 4 NA	81. sleep: insomnia	
22. appetite: decreased	0 1 2 3 4 NA	**52. Hair: Abnormal Growth**	0 1 2 3 4 NA	**Other**	
23. appetite: increased	0 1 2 3 4 NA	**53. Hair: Loss**	0 1 2 3 4 NA		
24. constipation	0 1 2 3 4 NA	**54. Rash/Hives**	0 1 2 3 4 NA		
25. diarrhea	0 1 2 3 4 NA	**55. Sunburns/Redness**	0 1 2 3 4 NA		
26. flatulence	0 1 2 3 4 NA	**56. Sweating: Decreased**	0 1 2 3 4 NA		
27. taste abnormality: metallic, etc.	0 1 2 3 4 NA	**57. Sweating: Increased**	0 1 2 3 4 NA		
28. thirst: Increased	0 1 2 3 4 NA	58. Chills	0 1 2 3 4 NA		

Measures

Blood Pressure: _____ **Pulse:** _____ **Temperature:** _____ **Weight:** _____

Other (specify):

Client Name:

Current Psychotropic, Antiepileptic, Other Drugs of Importance (e.g., anticholinergics, stool softeners, etc.), and Total Mg/Day

_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day

Rater Comments (cross-reference chart location if more space needed)

Is more specialized assessment data required or likely to be needed?
(e.g., more specific rating scale, assessment using behavioral measures, etc.)

☐ Yes (describe in comments) ☐ No

Rater Conclusion:

☐ No immediate action required: Physician review at next visit or quarterly meeting

☐ Action required: Semi-immediate physician review (57 days)

☐ Action required: Immediate physician review (572 hours)

Instructions:

1. Observe the client for 5-15 minutes in a quiet area.
2. Perform procedures to ascertain items (e.g., flex arm for rigidity, open mouth to check throat and saliva, watch arm swing while walking, etc.). If client is verbal, inquire as to problems on items (e.g., "Are you having trouble seeing what you read? Describe this to me"). If client is verbal, ask at least once an open-ended question (e.g., "How have you been feeling?" or "Is there anything bothering you we need to know about?").
3. Review data such as seizure counts. If possible, talk to and review comments by reliable staff, especially on items which cannot be directly observed during the exam such as eating or sleeping.
4. If a sign or symptom is present, it is scored. This does not mean it is necessarily a side effect. If an item is scored and an explanation exists, describe this in the RATER COMMENTS (e.g., the client displays severe tremor, but is 80 years old and has had severe tremor as part of diagnosed Parkinson's disease).
5. Document in the client's chart that the assessment was conducted. Provide the form to the prescriber for review and signature.
6. The prescriber reviews the assessment, determines and documents appropriate action, and signs the form.
7. The form is filed in client's chart according to facility procedure. Any follow-up actions should be documented in the chart.
8. Refer to the exam and summarize in regularly scheduled quarterly or other medication reviews. Summarize in such reviews the results or status of any follow-up actions.

Physician Comments (cross-reference chart location if more space needed)

Physician Conclusion (check one or more):

☐ No action necessary	☐ Contra-active/auxiliary drug
☐ Dose reduction	☐ Drug change
☐ Drug discontinuation	☐ Increased surveillance
☐ Drug-hold	☐ Lab or other tests/data

Physician Signature	**Date of Review**

Scoring:

(Bold items are primarily observable. Regular print items are primarily client verbalization, staff input, or chart review)

0: Not Present. The item is not observable or is within the range of normal.

1: Minimal. The item is difficult to detect. It is questionable if the item is in the upper range of normal. The client does not notice or comment on the item. Alternatively, the item may occur a couple of times in a noticeable but short non-intense and non-repetitive manner.

2: Mild. The item is present, but does not hinder the client's normal functioning; i.e., his or her level at pretreatment. While the client is in no extreme discomfort, it is annoyance to the client or may progress to future severity and problems if ignored. Alternatively, the item may be continuously displayed in a non-intense manner or may "come and go" several times in a noticeable but non-intense manner.

3: Moderate. The item is present and produces some degree of impairment to functioning, but is not hazardous to health. Rather, it is uncomfortable and/or embarrassing to the client. Alternatively, the item may be displayed in a semi-intense manner "more often than not."

4: Severe. The item is a definite hazard to well-being. There is significant impairment of functioning or incapacitation. Alternatively, the item may be displayed in an intense and continuous or nearly continuous manner.

NA: The item is not assessable. The client will not cooperate with the item, appropriate data is not available, etc.

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Psychiatric Referral Summary – Attachment A

Customer's Name _____ Birthdate _____ Age ____ Sex: Male ___ Female____
Address _____ Supporting Agency _____
_____ Contact Person _____ Phone _____
Phone _____ Legal Guardian? _____ Phone _____
Primary M.D. _____ Phone _____ Other M.D. _____ Phone _____
Disability(ies): _____
MRDDA Case/Resource Manager _____ Phone _____
Form completed by: _____ Date: _____ Relationship _____

Briefly describe why this person is being referred for a psychiatric evaluation:

Symptom(s)/Behavior(s) of concern (define, state frequency and severity of each symptom or behavior):

Previous Mental Health Involvement (list past counseling, behavioral interventions, diagnosis, psychiatric hospitalizations, crisis team contact, etc.):

Previous Psychoactive Medications (list):

List Other Agency Contacts and Phone Numbers (vocational, mental health, other therapists, etc.):

What has been tried previously (list intervention and results, if known)

Psychiatric Referral Summary (cont'd)

List Medical Concerns/Diagnoses

Current Medications/Daily Dose/Purpose

List any known unusual or adverse reactions to medications: _____

Describe the following characteristics of the person, if not already listed:

Sleep Pattern _____

Mood/Affect _____

Eating Appetite _____

Thinking/Cognition _____

Memory _____

Anxiety Level _____

Hyperactivity _____

Sensory Impairments _____

Allergies _____

Gynecological/Urinary Problems _____

Communication Impairment _____

Other Information that may be pertinent _____

Psychoactive Medication Treatment Plan
Introduction of New Medication – Attachment B

Customer's Name:_____ Date: _____

Address: _____

Supporting Agency: _____

Diagnosis and/or Description of Behavior for Which Medication is Prescribed:

_____

_____

_____

_____

Medication: _____ Dosage: _____

_____ _____

Length of Treatment Trial (considered sufficient to determine if medication is effective):

_____

_____

_____

_____

Behavioral Criteria to Evaluate Effectiveness of Medication (what changes in behavior, mood, thought or functioning should be expected):

_____

_____

_____

_____

Common Side Effects of the Medication(s) and Monitoring Plan:

_____

_____

_____

_____ _____

Prescribing Physician Provider Agency Staff

Consent for Use of Psychoactive Medication – Attachment C

Client Name:_____ Date: _____

Medication for Which Consent is Requested:_____

_____

Purpose for Which Medication is Prescribed:

_____

_____

_____

Information on Medication: See attached information sheet that describes the medication, dosage ranges, and possible side effects.

Questions regarding the use of this medication should be addressed to the prescribing physician listed below.

Name of Physician:_____

Telephone Number: _____

Consent Statement:

I have received information on this medication, the reasons for its use, and I have had the opportunity to get my questions about it answered. I consent to the use of this medication. I understand that failure to consent to this medication will not result in loss of services from the Mental Retardation Developmental Disabilities Administration (MRDDA). I also understand that I may withdraw my consent at any time, without loss of services from the Mental Retardation Developmental Disabilities Administration.

_____ _____

Signature of Client Date

_____ _____

Signature of Guardian Date

Monitoring of Side Effect Scale (MOSES)

Rating Date	Client Name

Rater Signature & Title

Scoring: See page 2 for details

0: None 2: Mild 4: Severe
1: Minimal 3: Moderate NA: Not Assessable

Instructions: See page 2. Bold items below are primarily observable. Regular print items are primarily client verbalization, staff input, or chart review.

Exam Type (Check one; if "other," specify in rater comments)

☐ Admission ☐ Baseline ☐ Dose Increase ☐ Drug Initiation ☐ 6-month ☐ Other

Ears/Eyes/Head		Musculoskeletal/Neurological		Urinary/Genital	
01. Blink Rate: Decreased	0 1 2 3 4 NA	**29. Arm Swing: Decreased**	0 1 2 3 4 NA	59. menstruation: absent/ irregular	While the side-effects in these two areas are often difficult to determine, please be aware they may occur depending on the specific drug profile. Be certain to inquire about these if the client is verbal.
02. Eyes: Rapid Vert/Horz	0 1 2 3 4 NA	**30. Contortions/Neck-Back Arching**	0 1 2 3 4 NA	60. sexual: activity decreased	
03. Eyes: Rolled Up	0 1 2 3 4 NA	**31. Gait: Imbalance/ Unsteady**	0 1 2 3 4 NA	61. sexual: activity increased	
04. Face: No Expression/ Masked	0 1 2 3 4 NA	**32. Gait: Shuffling**	0 1 2 3 4 NA	62. sexual: continual erection	
05. Tics/Grimace	0 1 2 3 4 NA	**33. Limb Jerking/Writhing**	0 1 2 3 4 NA	63. sexual: erection inability	
06. blurred/double vision	0 1 2 3 4 NA	**34. Movement: Slowed/ Lack Of**	0 1 2 3 4 NA	64. sexual: orgasm difficult	
07. ear ringing	0 1 2 3 4 NA	**35. Pill Rolling**	0 1 2 3 4 NA	65. urinary retention	
08. headache	0 1 2 3 4 NA	**36. Restlessness/Pacing/ Can't Sit Still**	0 1 2 3 4 NA	66. urination: decreased	
Mouth		37. **Rigidity**/complaints of muscle pains or aches	0 1 2 3 4 NA	67. urination: difficult/painful	
09. Drooling/Pooling	0 1 2 3 4 NA	**38. Tremor/Shakiness**	0 1 2 3 4 NA	68. urination: increased	
10. Dry Mouth	0 1 2 3 4 NA	39. complaints of jitteriness/ jumpiness	0 1 2 3 4 NA	69. urination: nocturnal/enuresis	
11. Gum Growth	0 1 2 3 4 NA	40. fainting/dizziness/upon standing	0 1 2 3 4 NA	**Psychological**	
12. Mouth/Tongue Movement	0 1 2 3 4 NA	41. seizures: increased	0 1 2 3 4 NA	**70. Agitation**	0 1 2 3 4 NA
13. Speech: Slurred/ Difficult/Slow	0 1 2 3 4 NA	42. tingling/numbness	0 1 2 3 4 NA	**71. Confusion**	0 1 2 3 4 NA
Nose/Throat/Chest		43. weakness/fatigue	0 1 2 3 4 NA	72. **Crying**/feelings of sadness	0 1 2 3 4 NA
14. Breast: Discharge	0 1 2 3 4 NA	**Skin**		73. **Drowsiness**/Lethargy/ Sedation	0 1 2 3 4 NA
15. Breast: Swelling	0 1 2 3 4 NA	**44. Acne**	0 1 2 3 4 NA	**74. Irritability**	0 1 2 3 4 NA
16. Labored Breathing	0 1 2 3 4 NA	**45. Bruising: Easy/ Pronounced**	0 1 2 3 4 NA	**75. Withdrawn**	0 1 2 3 4 NA
17. Nasal Congestion/ Runny Nose	0 1 2 3 4 NA	**46. Color: Blue/Coldness**	0 1 2 3 4 NA	76. attention/concentration difficulty	If seen: ▪ Circle item ▪ Enter under "Other" ▪ Assign intensity score
18. Sore Throat/Redness	0 1 2 3 4 NA	**47. Color: Flushing/Warm To Touch**	0 1 2 3 4 NA	77. morning "hangover"	
19. Swallowing: Difficult	0 1 2 3 4 NA	**48. Color: Pale/Pallor**	0 1 2 3 4 NA	78. nightmares/vivid dreams	
Gastrointestinal		**49. Color: Yellow**	0 1 2 3 4 NA	79. perceptual: hallucinations/ delusions	
20. **Vomiting**/nausea	0 1 2 3 4 NA	**50. Dry/Itchy**	0 1 2 3 4 NA	80. sleep: excessive	
21. abdominal pain	0 1 2 3 4 NA	**51. Edema**	0 1 2 3 4 NA	81. sleep: insomnia	
22. appetite: decreased	0 1 2 3 4 NA	**52. Hair: Abnormal Growth**	0 1 2 3 4 NA	**Other**	
23. appetite: increased	0 1 2 3 4 NA	**53. Hair: Loss**	0 1 2 3 4 NA		
24. constipation	0 1 2 3 4 NA	**54. Rash/Hives**	0 1 2 3 4 NA		
25. diarrhea	0 1 2 3 4 NA	**55. Sunburns/Redness**	0 1 2 3 4 NA		
26. flatulence	0 1 2 3 4 NA	**56. Sweating: Decreased**	0 1 2 3 4 NA		
27. taste abnormality: metallic, etc.	0 1 2 3 4 NA	**57. Sweating: Increased**	0 1 2 3 4 NA		
28. thirst: Increased	0 1 2 3 4 NA	58. Chills	0 1 2 3 4 NA		

Measures

Blood Pressure: _____ **Pulse:** _____ **Temperature:** _____ **Weight:** _____

Other (specify):

Client Name:

Current Psychotropic, Antiepileptic, Other Drugs of Importance (e.g., anticholinergics, stool softeners, etc.), and Total Mg/Day

_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day
_____	_____ mg/day	_____	_____ mg/day

Rater Comments (cross-reference chart location if more space needed)

Is more specialized assessment data required or likely to be needed?
(e.g., more specific rating scale, assessment using behavioral measures, etc.)

☐ Yes (describe in comments) ☐ No

Rater Conclusion:

☐ No immediate action required: Physician review at next visit or quarterly meeting

☐ Action required: Semi-immediate physician review (57 days)

☐ Action required: Immediate physician review (572 hours)

Instructions:

1. Observe the client for 5-15 minutes in a quiet area.
2. Perform procedures to ascertain items (e.g., flex arm for rigidity, open mouth to check throat and saliva, watch arm swing while walking, etc.). If client is verbal, inquire as to problems on items (e.g., "Are you having trouble seeing what you read? Describe this to me"). If client is verbal, ask at least once an open-ended question (e.g., "How have you been feeling?" or "Is there anything bothering you we need to know about?").
3. Review data such as seizure counts. If possible, talk to and review comments by reliable staff, especially on items which cannot be directly observed during the exam such as eating or sleeping.
4. If a sign or symptom is present, it is scored. This does not mean it is necessarily a side effect. If an item is scored and an explanation exists, describe this in the RATER COMMENTS (e.g., the client displays severe tremor, but is 80 years old and has had severe tremor as part of diagnosed Parkinson's disease).
5. Document in the client's chart that the assessment was conducted. Provide the form to the prescriber for review and signature.
6. The prescriber reviews the assessment, determines and documents appropriate action, and signs the form.
7. The form is filed in client's chart according to facility procedure. Any follow-up actions should be documented in the chart.
8. Refer to the exam and summarize in regularly scheduled quarterly or other medication reviews. Summarize in such reviews the results or status of any follow-up actions.

Physician Comments (cross-reference chart location if more space needed)

Physician Conclusion (check one or more):

☐ No action necessary	☐ Contra-active/auxiliary drug
☐ Dose reduction	☐ Drug change
☐ Drug discontinuation	☐ Increased surveillance
☐ Drug-hold	☐ Lab or other tests/data

Physician Signature	**Date of Review**

Scoring:

(Bold items are primarily observable. Regular print items are primarily client verbalization, staff input, or chart review)

0: Not Present. The item is not observable or is within the range of normal.

1: Minimal. The item is difficult to detect. It is questionable if the item is in the upper range of normal. The client does not notice or comment on the item. Alternatively, the item may occur a couple of times in a noticeable but short non-intense and non-repetitive manner.

2: Mild. The item is present, but does not hinder the client's normal functioning; i.e., his or her level at pretreatment. While the client is in no extreme discomfort, it is annoyance to the client or may progress to future severity and problems if ignored. Alternatively, the item may be continuously displayed in a non-intense manner or may "come and go" several times in a noticeable but non-intense manner.

3: Moderate. The item is present and produces some degree of impairment to functioning, but is not hazardous to health. Rather, it is uncomfortable and/or embarrassing to the client. Alternatively, the item may be displayed in a semi-intense manner "more often than not."

4: Severe. The item is a definite hazard to well-being. There is significant impairment of functioning or incapacitation. Alternatively, the item may be displayed in an intense and continuous or nearly continuous manner.

NA: The item is not assessable. The client will not cooperate with the item, appropriate data is not available, etc.

This scale is not a complete listing of all possible adverse drug reactions or effects and is not a substitute for other appropriate professional health care responsibilities, assessments, or testing.

Psychoactive Medication Treatment Plan
Annual Continuation of Medication – Attachment E

Customer's Name:_____
Date:_____

Address:_____

Supporting Agency:_____

Diagnosis and/or Description of Behavior for Which Medication is Prescribed:

_____

_____

Medication: _____
_____
_____

Dosage: _____
_____
_____

Positive Results of this Medication and Justification for Continuation:

Plan to Continue Use of This Medication:

_____ _____
Prescribing Physician Provider Agency Staff